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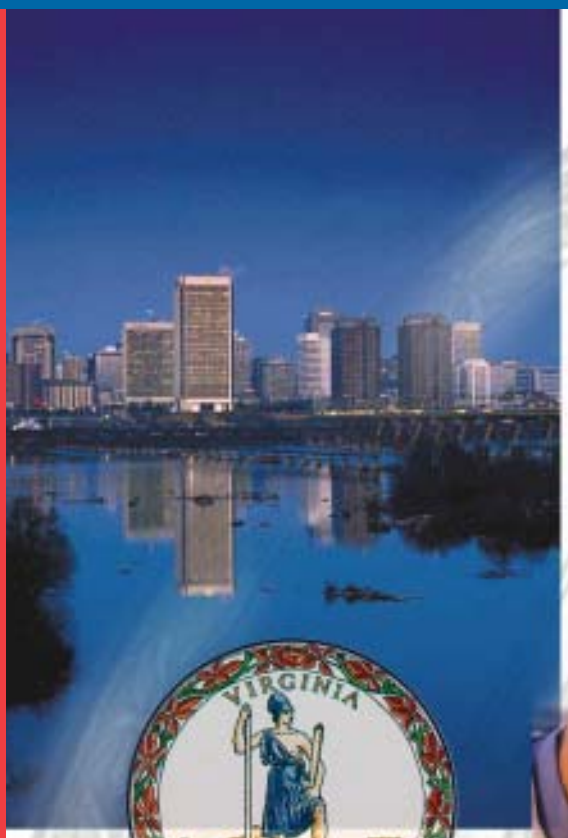

Commonwealth of Virginia Department of Medical Assistance Services

External Quality Review

Virginia Premier Health Plan

SFY 2005

We don't provide healthcare... we make it better.

Section I - Operational Systems Review

Introduction

The operational systems review provides an assessment of the structure, process, and outcomes of the MCO's internal operating systems. The purpose is to identify, validate, quantify, and monitor problem areas in the overall quality assurance program. The review incorporated regulations set forth under the Final Rule of the BBA that became effective on August 13, 2002. The BBA is the comprehensive revision to federal statutes governing all aspects of Medicaid managed care programs as set forth in section 1932 of the Social Security Act and title 42 of the *Code of Federal Regulations* (CFR), part 438 et seq. In support of these regulations and MCO contractual requirements, as part of the calendar year (CY) 2004 review, Delmarva evaluated the following systems:

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
  - Access Standards
  - Structure and Operation Standards
  - Measurement and Improvement Standards
- Grievance Systems—Subpart F Regulation

It is expected that each MCO will utilize the review findings and recommendations for operational systems improvement to become fully compliant with all standards and requirements.

Methodology

The operational systems standards used in the calendar year (CY) 2004 review were the same as those used in the 2003 review period (June through December 2003). These standards incorporate both the BBA and Medallion II contractual requirements. Specifically, in regards to the BBA, these standards include regulations under Subpart C, D, and F of the BBA.

The Operational Systems Review for the period July 2003 through December 2003 was conducted on-site at each MCO. Each element received a compliance rating of "met," "partially met," or "not met." Each element that was not fully met in the 2003 review was assessed as part of the calendar year (CY) 2004 review.

The CY 2004 review of Operational Systems consisted of a desk review of all documents provided by the MCO to assess compliance with all elements that were partially met or not met in the 2003 review. This

approach required Delmarva staff to conduct an evaluation of changes to policies, procedures, staff, and processes made by the MCO since the last review. The Delmarva team assessed all documentation provided by the MCO to assess whether or not the MCO had the administrative and operational systems in place and had implemented key operational policies and procedures to meet statutory requirements. During the process, the reviewers requested and the MCOs were asked to provide additional documentation or clarification where questions or concerns were identified.

As in the 2003 review, Delmarva review staff conducted the review, each element within a standard was rated as "met," "partially met," or "not met". Elements were then rolled up to create a determination of "met", "partially met", or "not met" for each of the standards related to enrollee rights and protections, quality assessment and performance improvement, and grievance system. Table 1 describes this scoring methodology.

Table 1. Rating Scale for Operational Systems Review

Rating	Rating Methodology
Met	All elements within the standard were met
Partially Met	At least half the required elements within the standard were met or partially met
Not Met	Less than half the required elements within the standard were met or partially met

The final element rating was determined as follows. All elements that were met in the 2003 review remained met for the CY 2004 review. All elements that were not fully met (partially met or unmet) were reviewed again and the CY 2004 review determination was applied. Therefore, the Operational Systems Review scores for the CY 2004 should increase from the 2003 year if the MCO made efforts to address the elements that were not fully met in the 2003 review.

Results

The overall performance rating for each of the three major standards is found in Table 2.

Table 2. Operational Systems Review Results by Standard – Calendar Year 2004 Results

Performance Standard	Overall Performance Rating
Subpart C- Enrollee Rights and Protections	Partially Met
Subpart D- Quality Assessment and Performance Improvement	Met
Subpart F- Grievance Systems	Partially Met

A total of 47 standards are evaluated as part of the Operational Systems Review. Of the seven (7) Enrollee Rights standards, three (3) were met and four (4) were partially met. All but one (1) of the 29 Quality Assessment and Performance Improvement standards was met. Ten (10) of the 11 Grievances Systems standards were met with the remaining standard receiving a partially met. None of the standards received a review determination of not met.

Results for each of the 47 Operational Systems Review elements contain within each of the three standards are presented in Table 3. The number of "Met" review determinations is a cumulative sum; it includes the number of elements met in the 2003 review plus those met in the CY 2004 Review.

Table 3. 2004 On-site Operational Systems Review Results for VA Premier.

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
ER 1	Written policies regarding enrollee rights and protections	10/1/0	Partially Met
ER 2	Information provided to enrollees upon enrollment and according to expected time frames	12/0/0	Met
ER 3	Information and language requirements	5/2/1	Partially Met
ER 4	Protected health information	3/0/0	Met
ER 5	Emergency and post-stabilization services	5/0/0	Met
ER 6	Advanced directives	4/1/0	Partially Met
ER 7	Rehabilitation Act, ADA	2/1/0	Partially Met
QA 1	Availability of services: network of appropriate providers	2/0/0	Met
QA 2	Availability of services: direct access to women's health specialist	1/0/0	Met
QA 3	Availability of services: second opinion	1/0/0	Met
QA 4	Availability of services: out of network	1/0/0	Met
QA 5	Cultural considerations	1/0/0	Met
QA 6	Coordination and continuity of care	1/0/0	Met
QA 7	Coordination and continuity of care: additional services for enrollees with special health care needs	1/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
QA 8	Direct access to specialists	2/0/0	Met
QA 9	Referrals and treatment plans	1/0/0	Met
QA 10	Primary care and coordination program	3/0/0	Met
QA 11	Coverage and authorization of services: processing of requests	9/0/0	Met
QA 12	Coverage and authorization of services-: notice of adverse action	1/0/0	Met
QA 13	Time frame for decisions: standard authorization decisions	1/0/0	Met
QA 14	Time frame for decisions: expedited authorization decisions	2/0/0	Met
QA 15	Provider selection: credentialing and recredentialing requirements	3/0/0	Met
QA 16	Provider selection: non-discrimination	1/0/0	Met
QA 17	Provider discrimination prohibited	1/0/0	Met
QA 18	Provider selection: excluded providers	1/0/0	Met
QA 19	Provider enrollment and disenrollment: requested by MCO	1/0/0	Met
QA 20	Provider enrollment and disenrollment: requested by the enrollee	2/0/0	Met
QA 21	Grievance systems	4/0/0	Met
QA 22	Subcontractual relationships and delegation	4/0/0	Met
QA 23	Practice guidelines	4/0/0	Met
QA 24	Dissemination of practice guidelines	0/1/0	Partially Met
QA 25	Application of practice guidelines	1/0/0	Met
QA 26	Quality assessment and performance improvement program	3/0/0	Met
QA 27	Under/over utilization of services	1/0/0	Met
QA 28	Care furnished to enrollees with special health needs	1/0/0	Met
QA 29	Health/management information systems	5/0/0	Met
GS 1	Grievance system	8/0/0	Met
GS 2	Filing requirements: procedures	2/0/0	Met
GS 3	Notice of action	1/0/0	Met
GS 4	Content of notice action	5/1/0	Partially Met
GS 5	Record-keeping and reporting requirements	1/0/0	Met
GS 6	Handling of grievances and appeals: special requirements for appeals	6/0/0	Met
GS 7	Resolution and notification: grievances and appeals—standard resolution	2/0/0	Met

Standard Number	Standard Description	Element Ratings Met/Partially Met/Not Met	Standard Rating
GS 8	Resolution and notification: grievances and appeals—expedited appeals	4/0/0	Met
GS 9	Resolution and notification	3/0/0	Met
GS 10	Requirements for state fair hearings	3/0/0	Met
GS 11	Effectuation of reversed appeal resolutions	2/0/0	Met

Scoring for the individual elements can be found in the Recommendations At-A-Glance Matrix in Appendix I-A1, including recommendations for elements that did not achieve full compliance. Detailed findings for each of the 47 review standards by element can be found in Appendix I-A2.

Conclusions and Recommendations

Conclusions

A total of 47 standards are evaluated as part of the Operational Systems Review. Of the seven (7) Enrollee Rights standards, three (3) were met and four (4) were partially met. All but one (1) of the 29 Quality Assessment and Performance Improvement standards was met. Ten (10) of the 11 Grievances Systems standards were met with the remaining standard receiving a partially met. None of the standards received a review determination of not met.

In the overall results VA Premier achieved a score of fully met for 41 of the standards evaluated as part of the review of Enrollee Rights, Quality Assessment, and Grievances systems. A review determination of partially met was achieved for the remaining six (6) standards. None of the 47 standards received a review determination of "Not Met" for the CY 2004 review.

Recommendations

The recommendations below are a summary of those included in the Detailed Findings section of this report (Appendix IA2). Implementation of these recommendations will facilitate full compliance in the next EQRO review as well as serve to strengthen the MCO's program.

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- VA Premier must revise the MCO Insolvency and/or Contract Termination policy to include specific procedures and the vehicle (such as the member handbook) for communicating to enrollees that they are not liable for payment in the event of MCO insolvency. There must also be language in the above policy that addresses how this information will be communicated to enrollees. Language in the Member Handbook is insufficient in addressing this element.

- VA Premier must have a policy that includes procedures for providing enrollee materials in alternative formats for enrollees who have limited reading proficiency or visual impairments (in the absence of an assistive telephone device). Language must be included in the Member Handbook that informs enrollees of the availability of alternate formats and how to request them.
- VA Premier must develop a policy and procedures for communicating to enrollees that oral interpretation in available for any language and written information is available in prevalent languages, and how to access those services. There must also be evidence that this information is communicated to enrollees.
- VA Premier must revise Member Rights for a Second Opinion policy to include procedures for communicating to enrollees the availability of a no-cost second opinion form a qualified health professional within or outside of the network.
- VA Premier must revise the draft Case Trakker policy to incorporate procedures for reporting audit findings and handling security violations.
- VA Premier must develop a policy that includes procedures for disseminating practice guidelines to enrollees and potential enrollees upon request.
- VA Premier must add language to its Notice of Action letters explaining that the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which he/she may be required to pay the cost of the services.
- VA Premier must revise the MCO Insolvency and/or Contract Termination policy to include specific procedures and the vehicle (such as the member handbook) for communicating to enrollees that they are not liable for payment in the event of MCO insolvency. There must also be language in the above policy that addresses how this information will be communicated to enrollees. Language in the Member Handbook is insufficient in addressing this element.
- VA Premier must have a policy that includes procedures for providing enrollee materials in alternative formats for enrollees who have limited reading proficiency or visual impairments (in the absence of an assistive telephone device). Language must be included in the Member Handbook that informs enrollees of the availability of alternate formats and how to request them.
- VA Premier must develop a policy and procedures for communicating to enrollees that oral interpretation in available for any language and written information is available in prevalent languages, and how to access those services. There must also be evidence that this information is communicated to enrollees.
- VA Premier must revise Member Rights for a Second Opinion policy to include procedures for communicating to enrollees the availability of a no-cost second opinion form a qualified health professional within or outside of the network.
- VA Premier must revise the draft Case Trakker policy to incorporate procedures for reporting audit findings and handling security violations.
- VA Premier must develop a policy that includes procedures for disseminating practice guidelines to enrollees and potential enrollees upon request.

- VA Premier must add language to its Notice of Action letters explaining that the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which he/she may be required to pay the cost of the services.

Appendix IA1
Recommendations At-A-Glance

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services					
1.1	Enrollee rights and responsibilities.	X			
1.2	Out of area coverage.	X			
1.3	Restrictions on enrollee's freedom of choice among network providers (431.51).	X			
1.4	Referrals to specialty care (422.113c).	X			
1.5	Enrollee notification – termination/change in benefits, services, or service delivery site.	X			
1.6	Procedures that instruct how to contact enrollee services and a description of the department and its functions.	X			
1.7	Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).	X			
1.8	List of non-English speaking languages spoken by which contracted provider.	X			
1.9	Provider-enrollee communications.	X			
1.10	Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.		X		VA Premier must revise the MCO Insolvency and/or Contract Termination policy to include specific procedures and the vehicle (such as the member handbook) for communicating to enrollees that they are not liable for payment in the event of MCO insolvency. There must also be language in the above policy that addresses how this information will be communicated to enrollees. Language in the Member Handbook is insufficient in addressing this element.

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
1.11	Enrollment/ Disenrollment.	X			
ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):					
2.1	Enrollee rights and responsibilities.				Exempt from the CY 2004 Review
2.2	Enrollee identification cards – descriptions, how and when to use cards.	X			
2.3	All Benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.	X			
2.4	Procedures for obtaining out-of-area coverage.	X			
2.5	Procedures for restrictions on enrollee's freedom of choice among network providers.	X			
2.6	The MCO's policy on referrals for specialty care.	X			
2.7	Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.				Exempt from the CY 2004 Review
2.8	Procedures on how to contact enrollee services and a description of the functions of enrollee services.	X			
2.9	Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
2.10	Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area; include identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.	X			
2.11	Procedures for provider-enrollee communications.	X			
2.12	Procedures for providing information on physician incentive plans for those enrollees who request it.	X			
2.13	Process for enrollment and disenrollment from MCO.	X			
ER3. Information and Language requirements (438.10)					
3.1	MCO written enrollee information is available in the prevalent, non-English languages (see DMAS contract) of its particular service area.	X			
3.2	Enrollee information is written in prose that is readable and easily understood.	X			
3.3	State requires Flesch-Kincaid readability of 40 or below (at or below 12th grade level).	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.4	Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program),notices advising LEP persons of the availability of free language assistance."	X			
3.5	MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.		X		VA Premier must have a policy that includes procedures for providing enrollee materials in alternative formats for enrollees who have limited reading proficiency or visual impairments (in the absence of an assistive telephone device). Language must be included in the Member Handbook that informs enrollees of the availability of alternate formats and how to request them.
3.6	MCO has policies and procedures in place to make interpretation services available and free of charge to the each potential enrollee and enrollee. This applies to all non-English languages, not just those the State identifies as prevalent.	X			
3.7	MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.		X		VA Premier must develop a policy and procedures for communicating to enrollees that oral interpretation in available for any language and written information is available in prevalent languages, and how to access those services. There must also be evidence that this information is communicated to enrollees.

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
3.8	MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.			X	In order to receive a finding of met in the next EQRO review; VA Premier must have a policy that includes procedures for informing enrollees and potential enrollees that information is available in alternate formats and how to access those formats.
ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA)					
4.1	MCO has a confidentiality agreement in place with providers who have access to PHI.	X			
4.2	The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).	X			
4.3	The Contractor shall make an individual's PHI available to the Department within thirty (30) days of an individual's request for such information as notified and in the format requested by the Department.	X			
ER5. Emergency and Post-Stabilization Services (438.114, 422.113c)					
5.1	MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.	X			
5.2	MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
5.3	MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.	X			
5.4	MCO has provided enrollees with a description of how to obtain emergency transportation and other medically necessary transportation. (Medical HelpLine Access).	X			
5.5	MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.	X			
ER6. Advanced Directives					
6.1	The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.	X			
6.2	MCO has requirements to allow enrollees to participate in treatment decisions/options.	X			
6.3	Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.	X			
6.4	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart C Regulations: Enrollee Rights and Protections					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.5	MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.		X		VA Premier must revise Member Rights for a Second Opinion policy to include procedures for communicating to enrollees the availability of a no-cost second opinion form a qualified health professional within or outside of the network.
ER7. Rehabilitation Act, ADA					
7.1	MCO is in compliance with Federal and State laws regarding enrollee confidentiality.		X		VA Premier must revise the draft Case Trakker policy to incorporate procedures for reporting audit findings and handling security violations. It is also recommended that the MCO demonstrate compliance with this policy by providing samples of quarterly audit reports and any recommendations or corrective actions during the review period as well as minutes from the Compliance Advisory Committee demonstrating review findings.
7.2	MCO has provided the enrollee with a description of their confidentiality policies.	X			
7.3	MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA1. 438.206 Availability of services (b)					
1.1	MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract as evidenced by the following:	X			
1.2	MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.	X			
QA2. 438.206 Availability of services (b)(2)					
2.1	MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventive care services, as well as a primary care provider.	X			
QA3. 438.206 Availability of services (b)(3)					
3.1	MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.	X			
QA4. 438.206 Availability of services (b)(4)					
4.1	MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA5. 438.206(c) (2) Cultural considerations					
5.1	The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.	X			
QA6. 438.208 Coordination and continuity of care					
6.1	MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.	X			
QA7. 438.208(c) 1-3 Coordination and continuity of care – additional services for enrollees with special health care needs					
7.1	The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.	X			
QA8. 438.208(c) (4) Direct Access to specialists					
8.1	The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.	X			
8.2	Referral guidelines that demonstrate the conditions under which PCPs make arrangements for referrals to specialty care networks.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA9. 438.208 (d) (2) (ii – iii) Referrals and Treatment Plans					
9.1	The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.	X			
QA10. 438.208(e) Primary Care and Coordination Program					
10.1	MCO coordinates services furnished to enrollee with those of other MCOs, PHPs, or PAHPs to prevent duplication.	X			
10.2	Coordination of care across settings or transitions in care.	X			
10.3	MCO has policies and procedures to protect enrollee privacy while coordinating care.	X			
QA11. 438.210 (b) Coverage and Authorization of Services - Processing of requests					
11.1	The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.	X			
11.2	MCO has policies and procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventative services, and basic prenatal care.	X			
11.3	The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.	X			
11.4	The MCO has policies and procedures in place for staff to consult with requesting providers when appropriate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
11.5	If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.	X			
11.6	Subcontractor's UM plan is submitted annually and upon revision.	X			
11.7	The MCO has policies and procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.	X			
11.8	MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.	X			
11.9	MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.	X			
QA12. 438.210 (c) Coverage and authorization of services - Notice of adverse action					
12.1	MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA13. 438.210 (d) (1) Timeframe for decisions – Standard Authorization Decisions					
13.1	MCO provides decision notice as expeditiously as enrollee's health condition requires, not to exceed 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.	X			
QA14. 438.210 (d) (2) Timeframe for decisions – Expedited Authorization Decisions					
14.1	The MCO has policies and procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) working days after receipt of the request for service.	X			
14.2	The MCO has policies and procedures relating to the extension time frames for expedited authorizations allowed under the state contract.	X			
QA15. 438.214 (b) Provider selection - Credentialing and recredentialing requirements					
15.1	The MCO has written policies and procedures for selection and retention of providers.	X			
15.2	MCO recredentialing process takes into consideration the performance indicators obtained through QIP, UM program, Grievances and Appeals, and Enrollee satisfaction surveys.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
15.3	MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.	X			
QA16. 438.214 (c) Provider selection -Nondiscrimination					
16.1	MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	X			
QA17. 438.12 (a, b) Provider discrimination prohibited					
17.1	For those individual or group providers who are declined, the MCO provides written notice with reason for decision.	X			
QA18. 438.214 (d) Provider Selection – Excluded Providers					
18.1	MCO has policies and procedures and adheres to ineligible provider or administrative entities requirements.	X			
QA19. 438.56 (b) Provider Enrollment and Disenrollment – requested by MCO					
19.1	MCO has policies and procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA20. 438.56 (c) Provider Enrollment and Disenrollment – requested by enrollee					
20.1	MCO has policies and procedures in place for enrollees to request disenrollment.	X			
20.2	MCO has policies and procedures and adheres to timeframes established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).	X			
QA21. 438.228 Grievance systems					
21.1	MCO has a process for tracking requests for covered services that were denied.	X			
21.2	MCO has process for fair hearing notification.	X			
21.3	MCO has process for provider notification.	X			
21.4	MCO has process for enrollee notification and adheres to state timeframes.	X			
QA22. 438.230 Subcontractual relationships and delegation					
22.1	MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.	X			
22.2	MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor; and	X			
22.3	MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
22.4	MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.	X			
QA23. 438.236 (a, b) Practice guidelines					
23.1	The MCO has adopted practice guidelines that meet current quality standards and the following:				
a)	Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.	X			
b)	Consider the needs of enrollees.	X			
c)	Are adopted in consultation with contracting health care professionals; and	X			
d)	Are reviewed and updated periodically, as appropriate.				
QA24. 438.236 (c) Dissemination of Practice Guidelines					
24.1	The MCO has policies and procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.		X		VA Premier must develop a policy that includes procedures for disseminating practice guidelines to enrollees and potential enrollees upon request.
QA25. 438.236 (d) Application of Practice Guidelines					
25.1	MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
QA26. 438.240 Quality assessment and performance improvement program					
26.1	MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.	X			
26.2	MCO is conducting 1 QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.	X			
26.3	The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	X			
QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services					
27.1	MCO's QAPI program has mechanisms to detect both underutilization and over utilization of the MCO services.	X			
QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs					
28.1	MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.	X			
QA29. 438.242 Health/Management Information systems					
29.1	The MCO has information systems capable of furnishing timely, accurate, and complete information about the MCO program.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart D Regulations: Quality Assessment and Performance Improvement					
		Met	Partially Met	Not Met	Recommendations To Meet Element
29.2	The MCO information system is capable of: a. Accepting and processing enrollment. b. Reconciling reports of MCO enrollment/ eligibility. c. Accepting and Processing provider claims and encounter data. d. Tracking provider network composition, access to services, grievances and appeals. e. Performing QI activities.	X			
29.3	Furnishing DMAS with timely, accurate, and complete clinical and administrative information.	X			
29.4	MCO ensures that data submitted by providers is accurate by: a. Verifying the accuracy and timeliness of reported data. b. Screening the data for completeness, logic, and consistency. c. Collecting the service information in standard formats for DMAS. d. Assigns unique identifiers to providers and requires that identifiers are used when providers submit data to the MCO.	X			
29.5	MCO uses encryption processes to send PHI over the internet.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
GS1. 438.402 (a, b) Grievance System					
1.1	MCO has written policies and procedures that describe the grievance and appeals process and how it operates.	X			
1.2	The definitions for grievances and appeals are consistent with those established by the state 7/03.	X			
1.3	Policies and procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the MCO program separately from other programs.	X			
1.4	Policies and procedures describe how MCO responds to grievances and appeals in a timely manner.	X			
1.5	Policies and procedures describe the documentation process and actions taken.	X			
1.6	Policies and procedures describe the aggregation and analysis of the data and use in QI.	X			
1.7	The procedures and any changes to the policies must be submitted to the DMAS annually.	X			
1.8	MCO provides information about grievance and appeals system to all providers and subcontractors.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS2. 438.402 (3) Filing Requirements- Procedures					
2.1	The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.	X			
2.2	The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.	X			
GS3. 438.404 Notice of Action					
3.1	Notice of action is written according to language and format requirements set forth in GS 438.10 Information Requirements.	X			
GS4. 438.404 (b) Content of Notice Action **Content of NOA explains all of the following:**					
4.1	The action taken and reasons for the action	X			
4.2	The enrollee's right to file an appeal with MCO.	X			
4.3	The enrollee's right to request a State fair hearing.	X			
4.4	The procedures for exercising appeal rights.	X			
4.5	The circumstances under which expedited resolution is available and how to request an expedited resolution.	X			
4.6	The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.		X		VA Premier must add language to its Notice of Action letters explaining that the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which he/she may be required to pay the cost of the services.

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
GS5. 438.416 Record Keeping and reporting requirements					
5.1	The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.	X			
GS6. 438.406 Handling of grievances and appeals – special requirements for appeals					
6.1	MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating the enrollee's condition or disease.	X			
6.2	MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.	X			
6.3	MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.	X			
6.4	MCO informs enrollee of limited time available for cases of expedited resolution.	X			
6.5	MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
6.6	MCO continues benefits while appeal or state fair hearing is pending.	X			
GS7. 438.408 Resolution and Notification: Grievances and Appeals – Standard Resolution					
7.1	MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires- not exceeding 30 days from initial date of receipt of the appeal.	X			
7.2	In cases of appeals decisions not being rendered within 30 days, MCO provides written notice to enrollee.	X			
GS8. 438.408 Resolution and Notification: Grievances and Appeals – Expedited Appeals					
8.1	MCO has an expedited appeal process.	X			
8.2	The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three (3) working days from the initial receipt of the appeal.	X			
8.3	MCO has a process for extension, and for notifying enrollee of reason for delay.	X			
8.4	MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.	X			
GS9. 438.408 (b -d) Resolution and notification					
9.1	MCO decisions on expedited appeals are in writing and include decision and date of decision.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	Partially Met	Not Met	Recommendations To Meet Element
9.2	For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a State fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.	X			
9.3	MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.	X			
GS10. 438.408 (c) Requirements for State Fair Hearings					
10.1	MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.	X			
10.2	MCO provides state with a summary describing basis for denial and for appeal.	X			
10.3	MCO faxes appeal summaries to state in expedited appeal cases.	X			
GS11. 438.410 Expedited resolution of appeals, GS. 438.424 Effectuation of reversed appeal resolutions					
11.1	The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or the state fair hearing department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.	X			

Performance Rating – Virginia EQRO Performance Standards Subpart F Regulations: Grievance Systems					
		Met	**Partially Met**	**Not Met**	**Recommendations To Meet Element**
11.2	MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.	X			

Subpart C Regulations: Enrollee Rights and Protections

ER1. The MCO has written policies regarding enrollee rights and protections and ensures that staff and affiliated providers take those rights into account when furnishing services.

Element 1.1 - Enrollee rights and responsibilities.
This element is met.

The VA Premier Health Plan policy, Member Rights and Responsibilities, was revised December 2004 to include the two required missing rights, the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation and the right to free exercise of rights and that exercise of those rights does not adversely affect the way the MCO and its providers treat the enrollee.

Element 1.2 - Out of area coverage.
This element is previously met - not reviewed.

Element 1.3 - Restrictions on enrollee's freedom of choice among network providers (431.51).
This element is previously met - not reviewed.

Element 1.4 - Referrals to specialty care (422.113c).
This element is previously met - not reviewed.

Element 1.5 - Enrollee notification – termination/change in benefits, services or service delivery site.
This element is previously met - not reviewed.

Element 1.6 - Procedures that instruct how to contact enrollee services and a description of department and its functions.
This element is previously met - not reviewed.

Element 1.7 - Procedures for grievances, appeals, and fair hearing procedures (438.10g, 438.400 – 438.424).
This element is previously met - not reviewed.

Element 1.8 - List of non-English languages spoken by contracted providers.
This element is previously met - not reviewed.

Element 1.9 - Provider-enrollee communications.
This element is previously met - not reviewed.

Element 1.10 - Procedures for sharing information with enrollees – that they are not liable for payment in case of MCO insolvency.
This element is partially met.

The VA Premier Health Plan policy, MCO Insolvency and/or Contract Termination, effective May 2004 includes a statement that enrollees will not be held liable for the debts of VA Premier in the event of insolvency and requires all members be advised of the contract termination effective date and provided with the Managed Care Help Line telephone number to address further questions. These procedures for enrollee notification of the termination date and a contact number for questions is insufficient in meeting the requirement of this element for developing procedures for communicating to enrollees that they are not liable in the case of MCO insolvency.

Recommendation:
In order to receive a finding of met in the next EQRO review it is recommended that VA Premier revise the above policy to include specific procedures and the vehicle (such as member handbook) for communicating to enrollees that they are not liable for payment in the event of MCO insolvency. Language in the Member Handbook is insufficient in meeting this requirement. There must also be language in the above policy that addresses how this information will be communicated to enrollees.

Element 1.11 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER2. Upon enrollment and according to expected timeframes, enrollees are provided a written statement that includes information on the following (see enrollee materials/brochures):

Element 2.1 - Enrollee rights and responsibilities.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting VA Premier in meeting this element in the next review.

VA Premier has provided a written statement dated May 9, 2005 that the two missing enrollee rights, the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation and the right to free exercise of rights and that exercise of those rights does not adversely affect the way the MCO and its providers treat the enrollee, have been included in proposed changes to the member handbook which is currently awaiting approval from the Bureau of Insurance. The Information Distribution policy, effective December 2004, includes procedures for providing new enrollees with a member handbook that contains a listing of enrollee rights and responsibilities. Existing enrollees are to receive a listing of enrollee rights and responsibilities in the enrollee newsletter, which is distributed in January and July. A copy of the January 2005 Member Newsletter included a comprehensive listing of all required enrollee rights. Based upon this review VA Premier has met the requirements of this element.

Element 2.2 - Enrollee identification cards – descriptions and how and when to use cards.
This element is previously met - not reviewed.

Element 2.3 - All benefits and services included and excluded as a condition of membership, including authorization requirements and any special benefit provisions that may apply to services obtained outside of the system.
This element is previously met - not reviewed.

Element 2.4 - Procedures for obtaining out-of-area coverage.
This element is previously met - not reviewed.

Element 2.5 - Procedures for restrictions on enrollee's freedom of choice among network providers.
This element is previously met - not reviewed.

Element 2.6 - The MCO's policy on referrals for specialty care.
This element is previously met - not reviewed.

Element 2.7 - Procedures for notifying enrollees affected by the termination or change in benefits, services, or service delivery site.
This element is exempt for the CY 2004 review.

The Department of Medical Assistance Services has exempted all MCOs from Evidence of Coverage/member handbook requirements for the 2004 review in response to delays experienced by some MCOs in receiving Bureau of Insurance approval of revisions to these documents. Review of this element will be for informational purposes only in assisting Optima in meeting this element in the next review.

A July 2005 draft of the Member Handbook includes a section on Change in Optima Benefits or Services advising enrollees that they will be notified in writing or through an update to the Member Handbook of any changes. Additionally, in the Your Rights section enrollees are advised that they will be notified at least 14 days before there are any program or site changes that affect them. This proposed revision satisfies the requirement of this element.

Element 2.8 - Procedures on how to contact enrollee services and a description of the functions of enrollee services.
This element is previously met - not reviewed.

Element 2.9 - Procedures for grievances, appeals, and fair hearing procedures, and the amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
This element is previously met - not reviewed.

Element 2.10 - Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the enrollee's service area, including identification of providers that are not accepting new patients. This includes, at a minimum, information on primary care physicians, specialists, and hospitals.
This element is previously met - not reviewed.

Element 2.11 - Procedures for provider-enrollee communications.
This element is previously met - not reviewed.

Element 2.12 - Procedures for providing information on physician incentive plans for those enrollees who request it.
This element is previously met - not reviewed.

Element 2.13 - Process for enrollment and disenrollment from MCO.
This element is previously met - not reviewed.

ER3. Information and Language requirements (438.10).

Element 3.1 - MCO written enrollee information is available in the prevalent, non-English languages spoken in its particular service area (see DMAS contract).
This element is met.

The May 2005 draft of the VA Premier Health Plan policy, Cultural Considerations, outlines procedures for translating enrollee materials into a prevalent non-English language once the prevalence of any specific non-English speaking language group exceeds five percent of the MCO's population. In the interim VA Premier will provide interpreter services for non-English speaking members. Procedures also address how VA Premier will collect data to assess the percentage of enrollees who are non-English speaking by language spoken. Data sources include a Customer Service Module field to capture language spoken when enrollees contact the Member Services call center, CAHPS enrollee survey data, and monthly usage reports of the AT&T Language Line.

Recommendation:
It is recommended that VA Premier revise the above policy to reflect the frequency of assessing the prevalence of non-English languages spoken by its membership.

Element 3.2 - Enrollee information is written in prose that is readable and easily understood.
This element is previously met - not reviewed.

Element 3.3 - State requires Flesch-Kincaid readability of 40 or higher (at or below 12th grade level).
This element is met.

The draft of VA Premier Health Plan policy, Flesch Readability Formula Testing, effective May 2005, outlines procedures for ensuring the required Flesch score of 40 utilizing the Flesch scoring tool in Microsoft Word prior to submitting any documents to the Department of Medical Assistance Services (DMAS) for approval. A sample Readability Statistics using the Flesch scoring tool revealed a Flesch reading ease score of 49.5 and a grade level of 11.0 for the June 2, 2003 member update.

Element 3.4 - Enrollee vital documents must be translated into non-English languages regularly encountered in the eligible population. Examples of vital documents include: "Applications, consent forms, letters containing important information about participation in programs (such as a cover letter outlining conditions of participation in a Medicaid managed care program), ...notices advising people with limited English proficiency of the availability of free language assistance."
This element is previously met - not reviewed.

Element 3.5 - MCO has provided written material in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.
This element is partially met.

VA Premier has provided a written statement dated May 9, 2005 that VA PREMIER will develop alternate materials for translation (ex. visually limited and limited reading proficiency) when the 5% threshold, per DMAS contract is reached. This is inconsistent with the Medallion II Managed Care Contract, dated July 1, 2003, which states that "the Contractor shall ensure that written membership material is available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited [42CFR438.10 (a)(1)(ii)]." The five percent threshold only applies to enrollees who speak a common non-English language, not the above enrollees.

As additional demonstration of compliance with this element VA Premier provided two policies, Translation Services and Cultural Considerations, which address primarily non-English speaking enrollees and enrollees with hearing impairments. The Translation Services policy relies on the Virginia Relay Center for communication with enrollees who are "deaf, hard of hearing, deafblind, or speech disabled". It does not address how communication will occur in the absence of the enrollee having access to an assistive telephone device or individuals with limited reading proficiency.

Recommendations:
In order to receive a finding of met in the next EQRO review, VA Premier must have a policy that includes procedures for providing enrollee materials in alternate formats for enrollees who have limited reading proficiency or visual impairments (in the absence of an assistive telephone device). There must be language included in the member handbook that informs enrollees of the availability of alternate formats and how to request them.

Element 3.6 - MCO has policies and procedures in place to make interpretation services available and free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those the state identifies as prevalent.
This element is previously met - not reviewed.

Element 3.7 - MCO has policies and procedures in place to notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages; and how to access those services.
This element is partially met.

As evidence of compliance with this element VA Premier provided two policies, Translation Services and Cultural Considerations, which include procedures for providing interpretation services for non-English speaking enrollees and enrollees with hearing impairments and translating member materials once a 5% threshold is met for a common non-English language. Neither policy addresses how VA Premier will notify enrollees that oral interpretation is available for any language and written information is available in a prevalent non-English language and how to access those services. A draft of the May 2005 Member

Handbook includes a statement in Spanish that directs an enrollee who need s assistance in Spanish to contact the following numbers.

Recommendations:
In order to receive a finding of met in the next EQRO review VA Premier must develop a policy and procedures for communicating to enrollees that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services. There must also be evidence that this information is communicated to enrollees.

Element 3.8 - MCO has policies and procedures in place to inform enrollees and potential enrollees that information is available in alternative formats and how to access those formats.
This element is not met.

In order to support compliance with this element VA Premier provided two policies, Translation Services and Cultural Considerations, which address primarily non-English speaking enrollees and enrollees with hearing impairments. There is no mention in either policy as to how VA Premier will inform enrollees and potential enrollees that information is available in alternate formats for enrollees who have limited reading proficiency or visual impairments and instructions for accessing those formats. The approved Member Handbook, dated June 6, 2005 includes language limited to instructions for accessing TTY/TTD services.

Recommendations:
In order to receive a finding of met in the next EQRO review, VA Premier must have a policy that includes procedures for informing enrollees and potential enrollees that information is available in alternate formats and how to access those formats.

ER4. 42 C.F.R. 431, Subpart F, and the Code of Virginia, Title 2.1, Chapter 26, (the Privacy Protection Act of 1976) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Element 4.1 - MCO has a confidentiality agreement in place with providers who have access to PHI.
This element is previously met - not reviewed.

Element 4.2 - The Contractor shall implement and maintain appropriate safeguards to prevent the use and disclosure of protected health information (PHI).
This element is previously met - not reviewed.

Element 4.3 - The Contractor shall make an individual's PHI available to the Department within 30 days of an individual's request for such information as notified and in the format requested by the Department.
This element is met.

The draft VA Premier Health Plan policy, Minimum Necessary, includes the required procedure for making available an individual's PHI to DMAS within 30 days of an individual's request as notified and in the format requested.

ER5. Emergency and Post-Stabilization Services (438.114, 422.113c).

Element 5.1 - MCO has policies and procedures in place that define emergency and post-stabilization situations, a description on what to do in an emergency, a telephone number and instructions for obtaining advice on getting care in an emergency, and that prior authorization is not needed.
This element is met.

The Virginia Health Plan policy, Emergency Department (ED) Appropriateness Criteria, revised May 2004, includes the required elements: the Prudent Layperson Standard for defining an emergency situation, definition of post stabilization services, procedures for instructing enrollees on what to do in emergent and non-emergent situations, and coverage criteria. While the policy does not explicitly state that pre-authorization for emergency services is not required the procedures for instructing enrollees to go immediately to the nearest emergency room for treatment in the event of an emergent situation satisfies this requirement. VA Premier has advised in written correspondence dated May 9, 2005 that the proposed changes to the enrollee handbook to include the definition of post stabilization and the waiver of any pre-authorization requirements have been submitted to the BOI for approval.

Recommendation:
It is recommended that VA Premier consider revising the above policy to explicitly state the waiver of any preauthorization requirements for emergency and post-stabilization services.

Element 5.2 - MCO has given enrollee information on how to utilize after-hours medical advice and enrollee services department.
This element is previously met - not reviewed.

Element 5.3 - MCO has processes and procedures in place for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
This element is previously met - not reviewed.

Element 5.4 - MCO has provided enrollees with a description of how to obtain emergency transportation and other medical necessary transportation (Medical HelpLine Access).
This element is previously met - not reviewed.

Element 5.5 - MCO has provided enrollees with locations of settings that furnish emergency and post-stabilization services covered by MCO.
This element is met.

The 2005 VA Premier Health Plan, Inc. Provider Directory for the Southwestern Western region includes a statement that all VA Premier participating hospitals provide both emergency and post stabilization services. Similarly, the 2004-2005 Tidewater edition includes such language.

ER6. Advanced Directives

Element 6.1 - The MCO has provided adult enrollees with written information on advance directives, including a description of the applicable state law.
This element is previously met - not reviewed.

Element 6.2 - MCO has requirements to allow enrollees to participate in treatment decisions/options.
This element is previously met - not reviewed.

Element 6.3 - Procedures to communicate the risks, benefits, and consequences of treatment or non-treatment.
This element is previously met - not reviewed.

Element 6.4 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

Element 6.5 - MCO has policies and procedures to inform enrollees that they may obtain a second opinion from a qualified health care professional within the network or outside the network if necessary, at no cost to enrollee.
This element is partially met.

The VA Premier Health Plan policy, Member Rights for a Second Opinion, effective May 2004, includes procedures for authorizing a no cost second opinion but does not include procedures for informing

enrollees of the availability of a no cost second opinion which is required by this element. The proposed change to include language in the enrollee handbook on the availability of a no cost second opinion from a qualified health care professional was in evidence in a draft excerpt from the May 2005 Member Handbook and EOC. This language, however, is insufficient in meeting the requirement for written procedures for communicating the availability of a no cost second opinion from a qualified health care professional within or outside of the network to the enrollee.

Recommendation:
In order to receive a finding of met in the next EQRO review it is recommended that VA Premier revise the above policy to include procedures for communicating to enrollees the availability of a no cost second opinion from a qualified health care professional within or outside of the network.

ER7. Rehabilitation Act, ADA

Element 7.1 - MCO complies with Federal and State laws regarding enrollee confidentiality.
This element is partially met.

The draft VA Premier Health Plan policy, CaseTrakker Security, outlines procedures for the Corporate Compliance Officer to conduct quarterly audits of CaseTrakker system access and breach in user security. The policy does not address procedures for reporting audit findings or handling security violations. The draft of the VA Premier policy, Patient Confidentiality Audits Within Managed Care Applications, outlines procedures for analyzing employee access to enrollee accounts utilizing the Patient Confidentiality Report. The Director of System Development as directed by the Corporate Compliance Officer is responsible for ensuring reports are generated on a quarterly basis and presented within five business days of the end of a quarter to the Corporate Compliance Officer. The Corporate Compliance Officer is responsible for conducting an investigation and undertaking other required actions on the basis of any reported violations. All findings are to be reported to the Compliance Advisory Committee. VA Premier did not submit any evidence of quarterly audits, recommendations, or corrective action plans in compliance with the above two policies.

Recommendations
In order to receive a finding of met in the next EQRO review it is recommended that VA Premier revise the draft CaseTrakker policy to incorporate procedures for reporting audit findings and handling security violations. It is also recommended that VA Premier demonstrate compliance with the above policies by providing samples of quarterly audit reports and any recommendations or corrective action during the review period as well as minutes from the Compliance Advisory Committee demonstrating review of findings.

Element 7.2 - MCO has provided the enrollee with a description of their confidentiality policies.
This element is previously met - not reviewed.

Element 7.3 - MCO has provided enrollee with information on how to obtain a copy of their medical record and how to request records from the MCO.
This element is previously met - not reviewed.

Subpart D Regulations: Quality Assessment and Performance Improvement

QA1. 438.206 Availability of services (b).

Element 1.1 - MCO has policies and procedures to maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract.
This element is previously met - not reviewed.

Element 1.2 - MCO has policies that allow enrollees with disabling conditions, chronic illnesses, or children with special health care needs to request their PCP be a specialist.
This element is previously met - not reviewed.

QA2. 438.206 Availability of services (b)(2).

Element 2.1 - MCO has policies and procedures to inform enrollees of direct access to women's health specialist within MCO network for routine and preventative care services, as well as a primary care provider.
This element is previously met - not reviewed.

QA3. 438.206 Availability of services (b)(3).

Element 3.1 - MCO has policies and procedures to provide for a second opinion from a qualified health care professional within the network, or to provide for the enrollee to obtain one outside the network, at no cost to the enrollee.
This element is met.

The VA Premier Health Plan policy, Member Rights for a Second Opinion, effective May 2004 includes procedures for allowing coverage at no cost to the enrollee for a second opinion by the provider of the same or similar specialty as the treating provider when requested by the enrollee, provider, or enrollee's representative. If VA Premier does not have a provider in the network of that specialty to provide a second opinion VA Premier is to authorize an out of plan referral for the visit.

QA4. 438.206 Availability of services (b)(4)

Element 4.1 - MCO has policies and procedures that provide necessary services out of network, if unable to cover necessary medical services required by enrollee.
This element is previously met - not reviewed.

QA5. 438.206(c)(2) Cultural considerations.

Element 5.1 - The MCO has policies and procedures to promote the delivery of services in a culturally competent manner to all enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.
This element is met.

The VA Premier Health Plan policy, Cultural Competency, requires training on cultural competence for all staff that deal directly or indirectly with enrollees. Training classes and seminars on cultural competence related issues are to be included in the annual Employee Training Calendar. The policy on Cultural Considerations also includes initiatives for promoting the delivery of services in a culturally competent manner including interpreter service, employment of bi-lingual Spanish speaking customer service representatives, and inclusion of a diverse representation of enrollees in the Member Advisory Committee. Neither policy includes procedures for evaluating the impact of these interventions on the delivery of culturally competent services to enrollees to determine whether they are achieving the stated goal(s).

Recommendation:
It is recommended that VA Premier revise the above policies to include procedures for evaluating the effectiveness of the interventions in promoting the delivery of services in a culturally competent manner to enrollees including those with limited English proficiency and diverse cultural and ethnic backgrounds.

QA6. 438.208 Coordination and continuity of care.

Element 6.1 - MCO has policies and procedures in place to ensure coordinated care for all enrollees and provide particular attention to needs of enrollees with complex, serious, and/or disabling conditions.
This element is previously met - not reviewed.

QA7. 438.208(c) 1-3 Additional services for enrollees with special health care needs.

Element 7.1 - The MCO makes a good faith effort to conduct an assessment of enrollees with complex, serious, and/or disabling conditions as identified and reported by the state, within 90 days receipt of notification of SSI children.
This element is previously met - not reviewed.

QA8. 438.208(c) (4) Direct access to specialists.

Element 8.1 - The MCO has policies and procedures that allow an enrollee with special needs to access a specialist as is appropriate for the condition and identified needs.
This element is previously met - not reviewed.

Element 8.2 - Referral guidelines that demonstrate the conditions under which PCPs arrange for referrals to specialty care networks.
This element is previously met - not reviewed.

QA9. 438.208 (d) (2) (ii – iii) Referrals and treatment plans.

Element 9.1 - The MCO has a mechanism in place for the development of a treatment plan by the specialist in consultation with the enrollee's PCP, with enrollee participation, and is approved in a timely manner.
This element is previously met - not reviewed.

QA10. 438.208(e) Primary care and coordination program.

Element 10.1 - MCO coordinates services furnished to enrollee with those of other MCOs, PIHP, PAHP to prevent duplication.
This element is met.

The VA Premier Health Plan policy, Member Transitions and Coordination of Care, revised September 2003 outlines procedures for coordinating care for transitioning enrollees with special needs with the relinquishing contractor.

Element 10.2 - Coordination of care across settings or transitions in care.

This element is met.

The VA Premier Health Plan policy, Member Transitions and Coordination of Care, revised September 2003 outlines procedures for transitioning enrollees to VA Premier from another health plan or transitioning from one provider to another. The policy, Referral Communication, revised September 2003, outlines requirements for coordination of care between primary and specialty providers including the timing and content of communications. The Medical Records Review policy, revised April 2005, outlines procedures for auditing enrollee medical records prior to provider recredentialing. The audit form includes a field for documenting compliance with requirements for continuity and coordination of care between primary and specialty care providers.

Element 10.3 - MCO has policies and procedures to protect enrollee privacy while coordinating care.
This element is previously met - not reviewed.

QA11. 438.210 (b) Coverage and authorization of services - processing of requests.

Element 11.1 - The MCO has policies/procedures in place for processing requests for initial and continuing authorizations of services.
This element is previously met - not reviewed.

Element 11.2 - MCO has policies/procedures in place to ensure that preauthorization requirements do not apply to emergency care, family planning services, preventive services and basic prenatal care.
This element is met.

The VA Premier policy, Emergency Department (ED) Appropriateness Criteria, as noted in ER 5.1 does not explicitly state that pre-authorization for emergency services is not required, however, the procedures for instructing enrollees to go immediately to the nearest emergency room for treatment in the event of an emergent situation satisfies this requirement. The Open Access to Family Planning policy, effective May 2004, specifies that preauthorization is not required for family planning services. The 2005 Utilization Management Program Description states that enrollees may seek emergency care as needed at participating or non-participating hospitals without prior authorization. It also includes a number of enrollee self-referral services, family planning services, OB/GYN care, annual mammograms, and the initial three behavioral health visits of the benefit year with a notation that a PCP referral or authorization is not required.

Recommendation:
It is recommended that VA Premier include adding language to existing policies or creating a new policy that clearly identifies the waiver of pre-authorization requirements for the above services. This will ensure that this requirement is memorialized in a policy rather than subject to omission in annual revisions to the UM Program Description.

Element 11.3 - The MCO monitors the application of review criteria for authorizations and takes corrective action to ensure consistent application.
This element is previously met - not reviewed.

Element 11.4 - The MCO has policies/procedures in place for staff to consult with requesting providers when appropriate.
This element is previously met - not reviewed.

Element 11.5 - If MCO delegates authorization decisions to subcontractors, the MCO has a mechanism to ensure that standards are met.
This element is previously met - not reviewed.

Element 11.6 - Subcontractor's utilization management plan is submitted annually and upon revision.
This element is previously met - not reviewed.

Element 11.7 - The MCO has policies/procedures in place that state any decision to deny service authorization requests or to authorize services in an amount, duration, or scope less than requested be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.
This element is previously met - not reviewed.

Element 11.8 - MCO's service authorization decisions are completed within 2 days of receipt of all necessary information.
This element is previously met - not reviewed.

Element 11.9 - MCO is prohibited from providing incentives for denial, limiting, or discontinuing medical services for enrollees.
This element is met.

The May 1, 2005 edition of the VA Premier Provider Manual includes a statement under the Medical Management Procedures section that VA Premier is prohibited from providing incentives for denying,

limiting, or discontinuing medical services for its enrollees inclusive of practitioners and VA Premier staff. In VA Premier correspondence to Delmarva Foundation dated May 9, 2005 VA Premier advised of the proposed change to the member handbook including similar information to the above.

QA12. 438.210 (c) Coverage and authorization of services - notice of adverse action.

Element 12.1 - MCO notifies provider and gives written notice of any decision to deny a service authorization request or to authorize as requested.
This element is previously met - not reviewed.

QA13. 438.210 (d) (1) Timeframe for decisions – standard authorization decisions.

Element 13.1 - MCO provides decision notice as expeditiously as enrollee's health condition requires, not exceeding 14 calendar days following receipt of request for service, with possible extension up to 14 additional calendar days if enrollee requests extension or MCO justifies a need for additional information.
This element is previously met - not reviewed.

QA14. 438.210 (d) (2) Timeframe for decisions – expedited authorization decisions.

Element 14.1 - The MCO has policies/procedures to make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three working days after receipt of the request for service.
This element is previously met - not reviewed.

Element 14.2 - The MCO has policies/procedures relating to the extension time frames for expedited authorizations allowed under the state contract.
This element is previously met - not reviewed.

QA15. 438.214 (b) Provider selection - credentialing and recredentialing requirements.

Element 15.1 - The MCO has written policies/procedures for selection and retention of providers using 2003 NCQA guidelines.
This element is previously met - not reviewed.

This element received a finding of partially met in the 2003 onsite review. In order to assess compliance with this element a review of credentialing and recredentialing files is required to ensure that VA Premier credentialing and recredentialing activities are consistent with their policies. Since a file review is outside of the scope of this desktop review credentialing and recredentialing files will be requested during the next onsite review.

Element 15.2 - MCO recredentialing process takes into consideration the performance indicators obtained through quality improvement projects (QIPs), utilization management program, grievances and appeals, and enrollee satisfaction surveys.
This element is previously met - not reviewed.

This element received a finding of partially met in the 2003 onsite review. In order to assess compliance with this element a review of recredentialing files is required to ensure that VA Premier incorporates/documents review of provider performance data consistent with its recredentialing policies. Since a file review is outside of the scope of this desktop review recredentialing files will be requested during the next onsite review.

Element 15.3 - MCO's policies and procedures identify the mechanism for reporting serious quality deficiencies, resulting in suspension or termination of a practitioner, to the appropriate authorities. There is evidence that this process is in place. There is a comprehensive provider appeals process. A review of provider appeals indicates that the process is followed according to policy and procedures.
This element is previously met - not reviewed.

QA16. 438.214 (c) Provider selection -nondiscrimination.

Element 16.1 - MCO provider selection policies and procedures do not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
This element is met.

The VA Premier Health Plan policy, Non Discrimination for Providers, revised May 2005 includes required language that VA Premier selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

QA17. 438.12 (a, b) Provider discrimination prohibited.

Element 17.1 - For those individual or group providers who are declined, the MCO provides written notice with reason for decision.
This element is previously met - not reviewed.

QA18. 438.214 (d) Provider Selection – excluded providers.

Element 18.1 - MCO has policies/procedures and adheres to ineligible provider or administrative entities requirements set forth in K. Provider Relations.
This element is previously met - not reviewed.

QA19. 438.56 (b) Provider enrollment and disenrollment – requested by MCO.

Element 19.1 - MCO has policies/procedures that define processes MCO follows when requesting disenrollment, and that the request is in accordance to state contract.
This element is previously met - not reviewed.

QA20. 438.56 (c) Provider enrollment and disenrollment – requested by enrollee.

Element 20.1 - MCO has policies/procedures in place for enrollees to request disenrollment.
This element is previously met - not reviewed.

Element 20.2 - MCO has policies/procedures and adheres to time frames established by state for notifying and transitioning enrollees to new PCPs after PCP disenrollment (30 calendar days for each).
This element is previously met - not reviewed.

QA21. 438.228 Grievance systems.

Element 21.1 - MCO has a process for tracking requests for covered services that were denied
This element is previously met - not reviewed.

Element 21.2 - MCO has process for fair hearing notification.
This element is previously met - not reviewed.

Element 21.3 - MCO has process for provider notification.
This element is previously met - not reviewed.

Element 21.4 - MCO has process for enrollee notification and adheres to state time frames.
This element is previously met - not reviewed.

QA22. 438.230 Subcontractual relationships and delegation.

Element 22.1 - MCO evaluates prospective subcontractor's ability to perform the activities to be delegated before delegation occurs.
This element is previously met - not reviewed.

Element 22.2 - MCO has a written agreement that specifies the activities and report responsibilities designated to the subcontractor.
This element is previously met - not reviewed.

Element 22.3 - MCO has a process for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
This element is previously met - not reviewed.

Element 22.4 - MCO performs an annual review of all subcontractors to evaluate performance and has a mechanism in place to report actions that seriously impact quality of care that may result in suspension/termination of licenses.
This element is previously met - not reviewed.

QA23. 438.236 (a, b) Practice guidelines.

Element 23.1 - The MCO has adopted practice guidelines that meet current NCQA standards and the following:

a) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.
This component is previously met - not reviewed.

b) Consider the needs of the enrollees.
This component is previously met - not reviewed.

c) Are adopted in consultation with contracting health care professionals.
This component is previously met - not reviewed.

d) Are reviewed and updated periodically, as appropriate.
This component is previously met - not reviewed.

QA24. 438.236 (c) Dissemination of practice guidelines.

Element 24.1 - The MCO has policies/procedures for the dissemination of guidelines to all affected providers and, upon request, to enrollees and potential enrollees.
This element is partially met.

There was no evidence of any policies or procedures for dissemination of practice guidelines to enrollees and potential enrollees upon request as noted in the 2003 review. A draft of the May 2005 Member Handbook and Evidence of Coverage includes information on the availability of VA Premier practice guidelines used to make medical necessity decisions. Enrollees are advised that they can access a copy of these guidelines by contacting Member Services at the number provided. A sample denial letter also advises that the enrollee or the enrollee's representative may request a copy of the criteria used to make the decision.

Recommendation:
In order to receive a finding of met in the next EQRO review VA Premier must develop a policy that includes procedures for disseminating practice guidelines to enrollees and potential enrollees upon request.

QA25. 438.236 (d) Application of practice guidelines.

Element 25.1 - MCO decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply are consistent with the established guidelines.
This element is previously met - not reviewed.

QA26. 438.240 Quality assessment and performance improvement program.

Element 26.1 - MCO has an ongoing quality assessment and performance improvement program for the services provided to this population.
This element is previously met - not reviewed.

Element 26.2 - MCO is conducting one QIP to achieve, through ongoing measurement and interventions, demonstrable and sustained improvement in significant aspects of clinical and non-clinical care that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.
This element is met.

VA Premier submitted one QIP, Quality Control in Asthma Management, for review. NCQA's Quality Improvement Activity form was used to document the QIP.

This QIP was re-evaluated by VA Premier following the 2003 review and incorporates recommendations that were made following the onsite review. The rationale for this study included MCO specific data relating to asthma related acute care admissions and emergency room visits, both of which ranked in the top five percent of all admissions and diagnoses. The QIP attributes the high frequency of inpatient admissions and emergency room visits to ineffective management of asthma conditions with controller medications. The purpose of the QIP is to test the effectiveness of interventions in an effort to improve asthma management and control issues. The QIP consists of three well defined indicators: 1) one or more prescriptions for cromolyn sodium, aerosol corticosteroid, and leukotriene, 2) hospital admissions per 1,000 members with asthma, and 3) emergency department visits per 1,000 members with asthma. Benchmarks were provided for all three measures from NCQA, Healthy People 2010, and the Centers for Disease Control. Baseline goals matched benchmarks for the first and third indicator. The second indicator identified a goal of 20 hospital admissions per 1,000 members versus a benchmark of 11.8. Administrative data was utilized for all three measures. Results for remeasurement 2, CY2004, were not available at the time of the review. A quantitative analysis for all three measures was provided comparing measurement year one (2003) to baseline year (2002). Additionally, a qualitative analysis addressing practitioner related barriers, opportunities, and interventions was documented for indicator one. The Interventions Table further identified barriers and related interventions addressing enrollees, practitioners, and the MCO with target dates for implementation.

Recommendations:
Once VA Premier receives its results for each indicator for measurement year 2004 there should be documentation of both a quantitative and qualitative analysis of the results including identified barriers if goals are not met and interventions linked to identified opportunities for improvement.

Element 26.3 - The MCO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.
This element is previously met - not reviewed.

QA27. 438.240 (b) (2) Basic elements of QAPI program – under/over utilization of services.

Element 27.1 - MCO's QAPI program has mechanisms to detect both underutilization and overutilization of the Medallion II services.
This element is met.

As evidence of compliance with this element VA Premier submitted their Over Utilization and Under Utilization policy, utilization data, and sample corrective action for two areas of identified over utilization. The UM Over and Under Utilization Table included the data element, relevance, upper threshold, actual performance Year 1, analysis, and intervention. There was also a document that addressed the results and conclusion of actions taken to address providers using two atypical antipsychotic medications for the same enrollee. This document noted that the Pharmacy and Therapeutics Committee had given its approval for VA Premier to do an analysis of membership that was utilizing more than one atypical antipsychotic medication and provide the identified practitioners with protocols generally accepted as guidelines for use of more than one medication in this class. VA Premier also provided evidence of a planned intervention to address inappropriate utilization of high cost antibiotics in the treatment of acute otitis media in children. In response to a follow-up request VA Premier submitted sample minutes from two Medical Management Committee meetings held in 2004 and two Pharmacy and Therapeutics Committee meetings from 2005, which are outside of the review period. Review of the Medical Management Committee minutes supports a process for systematic review of potential utilization issues, detailed analysis, and corrective action and follow up for identified issues. For example, in the Medical Management Committee minutes of February 20, 2004 there was a discussion of inappropriate Emergency Room utilization and an action plan to educate patients and refer them to their PCP. A plan was approved to monitor Emergency Room utilization on an ongoing basis.

QA28. 438.240 (b) (3) Basic elements of QAPI program – care furnished to enrollees with special health needs.

Element 28.1 - MCO QAPI program has mechanisms to assess the quality of care and services provided to enrollees with special needs.
This element is previously met - not reviewed.

QA29. 438.242 Health/management information systems.

Element 29.1 - The MCO has information systems capable of furnishing timely, accurate, and complete information about the Medallion II program.
This element is previously met - not reviewed.

Element 29.2 - The MCO information system is capable meeting requirements.
This element is previously met - not reviewed.

Element 29.3 - Furnishing DMAS with timely, accurate and complete clinical and administrative information.
This element is previously met - not reviewed.

Element 29.4 - MCO ensures that data submitted by providers are accurate by meeting requirements.
This element is previously met - not reviewed.

Element 29.5 - MCO uses encryption processes to send PHI over the Internet
This element is previously met - not reviewed.

Subpart F Regulations: Grievance Systems

GS1. 438.402 (a, b) Grievance system.

Element 1.1 - MCO has written policies and procedures that describe the grievance and appeals process and how it operates.
This element is previously met - not reviewed.

Element 1.2 - The definitions for grievances and appeals are consistent with those established by the state in July 2003.
This element is previously met - not reviewed.

Element 1.3 - Policies/procedures describe how the MCO intends to receive, track, review, and report all enrollee inquiries, grievances and appeals for the Medallion II program separately from the commercial program.
This element is previously met - not reviewed.

Element 1.4 - Policies/procedures describe how MCO responds to grievances and appeals in a timely manner.
This element is previously met - not reviewed.

Element 1.5 - Policies/procedures describe the documentation process and actions taken.
This element is previously met - not reviewed.

Element 1.6 - Policies/procedures describe the aggregation and analysis of the data and use in quality improvement.
This element is previously met - not reviewed.

Element 1.7 - The procedures and any changes to the policies/procedures must be submitted to the DMAS annually.
This element is previously met - not reviewed.

Element 1.8 - MCO provides information about grievance and appeals system to all providers and subcontractors.
This element is previously met - not reviewed.

GS2. 438.402 (3) Filing requirements- procedures.

Element 2.1 - The MCO has grievance and appeal forms and provides written procedures to enrollees who wish to register written grievances or appeals.
This element is previously met - not reviewed.

Element 2.2 - The MCO provides reasonable assistance in completing forms and taking other procedural steps including, but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
This element is met.

The VA Premier Health Plan policy, Translator Services, includes procedures for providing interpreter service for non-English speaking members and TDD/TTY services for hearing impaired enrollees. The policy specifically includes assistance with all enrollee related inquiries, grievances, and appeals. A draft of the May 2005 Member Handbook and Evidence of Coverage includes a statement in Spanish that if the enrollee needs assistance in Spanish to call the 24 hour Nurseline and the Managed Care Helpline toll-free numbers listed below. A draft enrollee notification of receipt of grievance letter, awaiting approval from DMAS, was submitted for review that includes instructions in Spanish and a contact number for enrollees needing assistance. The Fall 2004 Member Newsletter included information on the availability of the Member Services Department in providing assistance to enrollees with questions or concerns relating to inquiries, grievances, and appeals.

Recommendation:
While VA Premier does communicate the availability of general assistance with grievances and appeals in its member newsletter it is recommended that this service be included in the Member Handbook as well since required assistance may not be limited to just enrollees who speak Spanish.

GS3. 438.404 Notice of action.

Element 3.1 - Notice of action is written according to language and format requirements set forth in **GS.** 438.10 Information Requirements.
This element is previously met - not reviewed.

GS4. 438.404 (b) Content of notice of action.

Content of NOA explains all of the following:

Element 4.1 - The action taken and reasons for the action.
This element is previously met - not reviewed.

Element 4.2 - The enrollee's right to file an appeal with MCO
This element is previously met - not reviewed.

Element 4.3 - The enrollee's right to request a state fair hearing.
This element is previously met - not reviewed.

Element 4.4 - The procedures for exercising appeal rights.
This element is previously met - not reviewed.

Element 4.5 - The circumstances under which expedited resolution is available and how to request an expedited resolution.
This element is previously met - not reviewed.

Element 4.6 - The circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.
This element is partially met.

The NOA letters submitted for review did not contain language explaining the circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services.

The policy *Member Inquiries, Notices, Grievances and Appeals Processes* has a section entitled "Content of the NOA" that states that an explanation of the circumstances under which the enrollee has the right to request that benefits continue pending appeal resolution and the circumstances under which the enrollee may be required to pay the costs of services are included in the written NOA. This information in the policy should be in the NOA that is sent to the enrollee.

Recommendation:
In order to receive a finding of met in the next review it is recommended that VA Premier add language to the NOA letters explaining that the enrollee has the right to request that benefits continue pending

appeal resolution and the circumstances under which he/she may be required to pay the cost of the services.

GS5. 438.416 Record keeping and reporting requirements.

Element 5.1 - The MCO maintains a record keeping and tracking system for inquiries, grievances, and appeals that includes a copy of the original grievance or appeal, the decision, and the nature of the decision.

This element is previously met - not reviewed.

GS6. 438.406 Handling of grievances and appeals – special requirements for appeals.

Element 6.1 - MCO has policies that ensure that individuals who make decisions on grievances and appeals were not involved in previous levels of reviews or decision-making and are health care professionals with appropriate level of expertise in treating enrollee's condition or disease.

This element is previously met - not reviewed.

Element 6.2 - MCO provides that oral inquires seeking to appeal an action are treated as appeals and confirmed in writing, unless enrollee or provider request expedited resolution.

This element is previously met - not reviewed.

Element 6.3 - MCO provides enrollee with reasonable opportunity to present evidence and allegation of the fact or law in person, as well as in writing.

This element is previously met - not reviewed.

Element 6.4 - MCO informs enrollee of limited time available for cases of expedited resolution.

This element is previously met - not reviewed.

Element 6.5 - MCO provides enrollee, representative, or legal representation of a deceased enrollee before and during the appeal process, to examine the enrollee case file, including medical records, considered during the appeal process.

This element is previously met - not reviewed.

Element 6.6 - MCO continues benefits while appeal or state fair hearing is pending.

This element is previously met - not reviewed.

GS7. 438.408 Resolution and notification: grievances and appeals – standard resolution.

Element 7.1 - MCO responds in writing to standard appeals as expeditiously as enrollee's health condition requires-not exceeding 30 days from initial date of receipt of the appeal.
This element is previously met - not reviewed.

Element 7.2 - In cases of appeal decisions not being rendered within 30 days, MCO provides written notice to enrollee.
This element is previously met - not reviewed.

GS8. 438.408 Resolution and notification: grievances and appeals – expedited appeals.

Element 8.1 - MCO has an expedited appeal process.
This element is previously met - not reviewed.

Element 8.2 - The Contractor shall issue decisions for expedited appeals as expeditiously as the enrollee's health condition requires, not exceeding three working days from the initial receipt of the appeal.
This element is previously met - not reviewed.

Element 8.3 - MCO has a process for extension, and for notifying enrollees of reason for delay.
This element is previously met - not reviewed.

Element 8.4 - MCO makes reasonable efforts to provide the enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the enrollee and shall follow-up within two calendar days with a written notice of action.
This element is previously met - not reviewed.

GS9. 438.408 (b-d) Resolution and notification.

Element 9.1 - Decisions by the MCO to expedite appeals are in writing and include decision and date of decision.
This element is previously met - not reviewed.

Element 9.2 - For decisions not wholly in favor of enrollee, the MCO provides the enrollee with the right to request a state fair hearing and how to do so, and the right to request to receive benefits while the hearing is pending and how to make the request, explaining that the enrollee may be held liable for the cost of those services if the hearing decision upholds the MCO.
This element is previously met - not reviewed.

Element 9.3 - MCO gives enrollee oral notice of denial and follow up within 2 calendar days with written notice.
This element is previously met - not reviewed.

GS10. 438.408 (c) Requirements for state fair hearings.

Element 10.1 - MCO educates enrollees on state's fair hearing process and that appeal must be in writing within 30 days of enrollee's receipt of notice of any action to deny, delay, terminate, or reduce services authorization request.
This element is previously met - not reviewed.

Element 10.2 - MCO provides state with a summary describing basis for denial and for appeal.
This element is previously met - not reviewed.

Element 10.3 - MCO faxes appeal summaries to state in expedited appeal cases.
This element is previously met - not reviewed.

GS11. 438.410 Expedited resolution of appeals, GS. 438.424 effectuation of reversed appeal resolutions.

Element 11.1 - The MCO must authorize the disputed services promptly and as expeditiously as the enrollee's health condition requires in cases where MCO or State Fair Hearing Department reverses a decision to deny, limit, or delay services, in cases where those services were not rendered.
This element is previously met - not reviewed.

Element 11.2 - MCO provides reimbursement for those services in accordance with terms of final agreement by state's appeal division.
This element is previously met - not reviewed.

Summary of Documents Reviewed		
Element	**Document**	**Date**
ER 1	VA Premier Health Plan Policy and Procedure: Policy #MS-015 Member Rights and Responsibilities	12/16/2004 revised
	VA Premier Health Plan Policy and Procedure: Policy #MS-033 MCO Insolvency and/or Contract Termination	05/24/2004 effective
	Medicaid Member Handbook (approved)	06/06/2005
ER 2	VA Premier Health Plan correspondence to Delmarva Foundation regarding ER 2.1 Member Rights	05/09/2005
	VA Premier Health Plan Policy and Procedure: Policy #MS-035 Information Distribution	12/16/2004 effective
	Member Newsletter	01/2005
ER 3	VA Premier Policy and Procedure: Policy #MS-026 Translation Services	12/16/2004 revised
	VA Premier Policy and Procedure: Policy #MS-036 Cultural Consideration (draft)	05/23/2005 effective
	VA Premier Health Plan Policy and Procedure: Policy #MS-037 Flesch Readability Formula Testing (draft)	05/23/2005 effective
	Member Update	06/2003
	Member Handbook and Evidence of Coverage (draft)	05/2005
	Medicaid Member Handbook (approved)	06/06/2005
ER 4	VA Premier Health Plan Policy and Procedure: Policy #COMP-006, Minimum Necessary (Draft)	10/01/2003 effective
ER 5	VA Premier Health Plan Policy and Procedure; Policy #UTM-015 Emergency Department (ED) Appropriateness Criteria	05/20/2004 revised
	Utilization Management Program Description	2005
	VA Premier Health Plan correspondence to Delmarva Foundation regarding ER 5.1	05/09/2005
	VA Premier Health Plan, Inc. Provider Directory Southwestern Western	2005
	VA Premier Health Plan, Inc. Provider Directory Tidewater	2004-2005
ER 6	VA Premier Health Plan Policy and Procedure: Policy #UTM-041 Member Rights for a Second Opinion	05/24/2004 revised
	Member Handbook and Evidence of Coverage (draft)	05/2005
ER 7	VA Premier Health Plan Policy and Procedure: Policy #IS-021 CaseTrakker Security (draft)	10/01/2003 effective
	VA Premier Health Plan Policy and Procedure: Policy #IS-022 Patient Confidentiality Audits Within Managed Care Applications (draft)	08/29/2003 revised
QA 3	VA Premier Health Plan Policy and Procedure: Policy #UTM-041 Member Rights for a Second Opinion	05/24/2004 revised
QA 5	VA Premier Policy and Procedure: Policy # MS-036 Cultural Consideration (draft)	05/23/2005 effective
	VA Premier Health Plan Policy and Procedure: Policy #HR-019 Cultural Competency	05/20/2004 effective
QA 10	VA Premier Policy and Procedure: Policy #UTM-019 Member Transitions and Coordination of Care	09/15/2003revised
	Utilization Management Program Description	2005
	VA Premier Health Plan Policy and Procedure: Policy #UTM-029 Referral Communication	09/23/2003 revised

Summary of Documents Reviewed		
Element	**Document**	**Date**
	VA Premier Health Plan Policy and Procedure: Policy #QM-005 Medical Records Review	04/14/2005 revised
	VA Premier Health Plan Physician Satisfaction Survey	09/24/2002
QA 11	VA Premier Health Plan Policy and Procedure: Policy #UTM-039 Pre-Authorization of Urgent Care Services	03/17/2004 revised
	VA Premier Health Plan Policies and Procedures: Policy #MS-032 Open Access to Family Planning	05/21/2004 effective
	VA Premier Health Plan Policy and Procedure: Policy #UTM-022 Authorization of OB Ultrasound and Non-Stress Test	10/2000 revised
	Utilization Management Program Description	2005
	VA Premier Health Plan Policy and Procedure; Policy #UTM-015 Emergency Department (ED) Appropriateness Criteria	05/20/2004 revised
	VA Premier Health Plan Provider Manual	05/01/2005
	VA Premier Health Plan correspondence to Delmarva Foundation regarding QA 11.9	05/09/2005
QA 15	VA Premier Health Plan Policy and Procedure: Policy #QM-002 Office Site Visits for Initial Credentialing	11/12/2003 revised
	VA Premier Health Plan Policy and Procedure: Policy #QM-005 Medical Records Review	04/14/2005 revised
	VA Premier Health Plan Policy and Procedure: Policy #CRE-017 Credentialing Program Description	12/17/2004 revised Undated
	VA Premier Health Plan Policies and Procedures: Policy #QM-008 Recredentialing Provider Profile	11/12/2003 revised
	VA Premier Health Plan Quality Improvement Recredentialing Provider Profile	Undated
QA 16	VA Premier Health Plan Policy and Procedure: Policy #CON-031	05/20/2004 revised
QA 24	Member Handbook and Evidence of Coverage (draft)	05/2005
	Sample Denial Letter	Undated
QA 26	Quality Improvement Activity Form: Quality Control in Asthma Management	07/01/2003 effective
QA 27	VA Premier Policy and Procedure: Policy #UTM-036 Over Utilization and Under Utilization	09/15/2003 revised
	UM over and under utilization table	Undated
	Over utilization of Atypical Antipsychotic Medications	Undated
	Inappropriate utilization of high cost antibiotics for acute otitis media	Undated
	Medical Management Committee minutes	02/20/2004, 03/19/2004
	Pharmacy and Therapeutics Committee minutes	01/07/2005, 04/01/2005
GS 2	VA Premier Health Plan Policy and Procedure: Policy #MS-026 Translation Services	12/16/2004 revised
	VA Premier Health Plan Policy and Procedure: Policy #MS-036 Cultural Considerations (draft)	05/23/2005 effective
	Member Handbook and Evidence of Coverage (draft)	05/2005
	Sample notification letter to enrollee related to receipt of grievance (draft)	Undated
	Language Line Summary Report- Usage by Language	04/03/2005
	Member Newsletter	Fall 2004

Summary of Documents Reviewed		
Element	**Document**	**Date**
GS 4	VA Premier Policy and Procedure: Policy#UTM-003 Appeals Process for Clinical Issues	09/28/2003 revised
	VA Premier Health Plan Policy and Procedure: Policy #UTM-033 Standard for Pharmacy Prior Authorization Process	09/29/2003 revised
	NOA Medicaid Denial of an Appeal	Undated
	NOA Medicaid Initial Denial (draft)	Undated